Written Ministerial Statement

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Department of Health

NEUROLOGY RECALL COHORT 3 ACTIVITY AND OUTCOMES REPORT, NEUROLOGY RECALL SUMMARY REPORT AND NEUROLOGY COMPENSATION ARRANGEMENTS

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Mr Swann (The Minister of Health): Today I announce to the Assembly the publication of the "Neurology Recall: Cohort 3 Activity and Outcomes Report", accompanied by the "Neurology Recall Cohort 1, 2 and 3 Summary Report". This marks the completion of the final recall of neurology patients who were under the care of former consultant Dr Michael Watt.

I will also outline the work undertaken relating to neurology recall compensation arrangements going forward and I will provide an up to date position on the RQIA Deceased Patients Review.

Cohort 3 Activity and Outcomes Report

In April 2021, I announced the publication of the Outcomes Report relating to Cohort 2 of the Neurology Recall. At that time, I also announced the recall of a third cohort of patients.

Cohort 3 comprises those people who had been under the care of Dr Watt between June 1996 and March 2012 who had returned to the care of their General Practitioner (GP), had not subsequently been under the care of another consultant neurologist, and had been prescribed one or more specific medications during the period 1 February 2020 to 31 July 2020.

Cohort 3 further included those people who had been under the care of Dr Watt, who had not been seen in the previous cohorts and who were identified as falling into the category of 'young stroke patients' due to the extension of the age range of those reviewed within Cohort 2.

A total of 768 people were included in Cohort 3. After further stratification undertaken in conjunction with Primary Care, 602 people were invited to attend recall appointments, of which 495 individuals attended. In line with Cohort 1 and Cohort 2the clinicians conducting the reviews were asked to consider whether the individual's diagnosis was secure, whether a proper management plan was in place for the individual and whether their current prescribing was appropriate.

It is important to emphasise that, again in line with Cohorts 1 and 2, the purpose of the recall was to ensure that the individuals affected were receiving the care and treatment that they required, rather than to provide a definitive assessment of Dr Watt's practice.

One key difference in the completion of the third recall was the involvement of Primary Care in reviewing the clinical notes of some individuals identified. Additional information from an individual's GP was required for those who were being prescribed low-risk anti-platelet mediation, to establish whether a further consultation was needed.

The Cohort 3 Outcomes Report shows that of the 495 patients of Dr Watt who were assessed by the reviewing clinicians, 380 had a diagnosis that was considered to be "secure" and 87 had a diagnosis that was considered "not secure" while, for 28 patients, there was "uncertainty" in respect of whether the previous diagnosis was secure. It is important to highlight that a diagnosis that was considered "not secure" does not necessarily equate to a misdiagnosis.

The Neurology Recall Summary Report, which is published alongside the Cohort 3 Outcomes Report, provides a high level breakdown of the data and outcomes for the Cohort 1, 2 and 3 recalls.

In the entirety of the neurology recall, the total number of people eligible for recall was 5,448, of which 4,179 attended recall appointments. The combined average percentage of people in Cohort 1, 2 and 3 whose diagnosis was considered “not secure” at the time of their recall appointment was 19%, equating to around 1 in 5 of people seen as part of the recall, with broadly similar outcomes in respect of an appropriate management plan and prescribing.

Although the reports published today are statistical in nature, it is important to highlight and acknowledge the patients and families these figures represent, and the exceptionally difficult and frustrating circumstances which they have experienced. I again wish to apologise unreservedly for the hurt caused to neurology recall patients and families affected by these matters, and I would like to reiterate my thanks and appreciation to them for their co-operation and patience during this process.

The publication of the Cohort 3 Activity and Outcomes Report and the Neurology Recall Summary Report is a significant milestone following the announcement of the initial recall of patients in May 2018. However, I appreciate that this does not offset the stress and anxiety caused to the patients and families affected. With this in mind, I do hope that the completion of the neurology recall provides assurance that no further recall is required.

I wish to thank the clinical and administrative staff who have completed the neurology recall and the support provided by the Patient and Client Council (PCC), the neurology charities and neurology support groups during this period.

Neurology Recall Patients have been supported by the Belfast Trust for all cohorts of the recall, including access to services for psychological and emotional issues where needed. The Belfast Trust Neurology Advice Line remains open Monday to Friday from 9am to 5pm with the exception of public / bank holidays. The telephone number is 0800 980 1100. Patients can also access the Belfast Trust Neurological Care Advisory Service, which offers a signposting to support services, charities and organisations for those living with a chronic neurological condition. The contact telephone number for this service is 028 9504 2270 and it is open Monday to Friday 9am to 5pm daily, excluding bank holidays.

The Department will continue to engage with neurology recall stakeholder groups through the PCC. The recently enhanced Neurology Engagement Platform, facilitated by the PCC, offers a formal engagement channel to address any concerns relating to the various work streams initiated by the Department, as a result of the neurology recall.

Neurology Compensation

Members will be aware that in 2018 the Department announced a neurology work stream to consider a potential neurology redress scheme. A Project Board was established and work has been undertaken to identify a way forward.

Neurology recall cases are very complex in nature and every claimant should be entitled to receive the compensation they deserve. It is only fair that each case is considered on its own merit and that claims are progressed as quickly as possible to provide claimants with compensation, in all appropriate cases.

A streamlined pathway has been developed to deliver this. This includes the potential to instruct a “joint expert” to provide a joint medical report at no expense to eligible claimants. This innovative approach is supported by a set of guiding principles to ensure eligible cases are progressed as quickly as possible.

Guidance is also being developed for neurology recall patients and families to support a clearer understanding of the claims process which will include advice on the streamlined claims process.

The Department cannot provide legal advice to neurology recall patients and families but it is hoped that the support information which is being developed, and which will be made available through the PCC, will assist the patients and families. The PCC advocacy service also provides independent support for neurology recall patients who have a concern about their health and social care.

It is important to highlight that claims in respect Dr Watt’s private patients fall outside the remit of the Department and the Belfast Trust. In respect of patients of Dr Watt’s treated in a private capacity, the relevant independent healthcare provider should be contacted, to initiate a clinical negligence claim.

The Belfast Trust's legal advisers are engaging with representatives of the independent providers to inform them of the streamlined pathway and the support materials which are being developed. It will be for the independent provider to determine if they wish to take a similar approach to addressing neurology recall claims.

Finally and significantly, in order to further ensure that neurology recall claims are progressed as a quickly as possible, I can confirm that a dedicated Neurology Recall Legal Team is now in place with the aim of progressing claims at pace and offering the streamlining of cases where possible and significant progress in advancing neurology recall claims has been made.

Legal processes, particularly in such complex cases, can sometimes be long and appear daunting for patients, however it is essential to ensure that a just outcome for patients and families is provided in respect of each case.

Justice, resolution, remedy and closure can take many forms. It is important to highlight that neurology recall patients and family voices are being heard and the Department will continue to engage with neurology patients and families, neurology charities and support groups including the formal Neurology Engagement Platform, facilitated by the PCC.

RQIA Deceased Patients Review

My Oral Assembly Statement, dated 20 April 2021, provided an update on the Expert Review of the clinical case notes of the patients of Dr Michael Watt who died in the 10 years prior to the neurology recall (i.e, the "Deceased Patients Review"), which was announced by the Department in May 2018. This statement confirmed the commencement of Phase Two of the Deceased Patients Review which pertains to the expert review of clinical records (involving 45 patient records), in which the Royal College of Physicians has been commissioned to support the review.

Phase Two, has included significant RQIA engagement with families and commenced in April 2021. The final reports are expected to be submitted to the Department by the end of June 2022. The RQIA's Family Liaison Team have assured the families involved that they will be in contact to offer feedback on the findings, to those who wish to receive this.

The Department and RQIA will consider the findings from the Deceased Patients Review Phase Two to inform decisions regarding next steps and the outcome of these considerations will be confirmed and communicated at the earliest opportunity.

ENDS